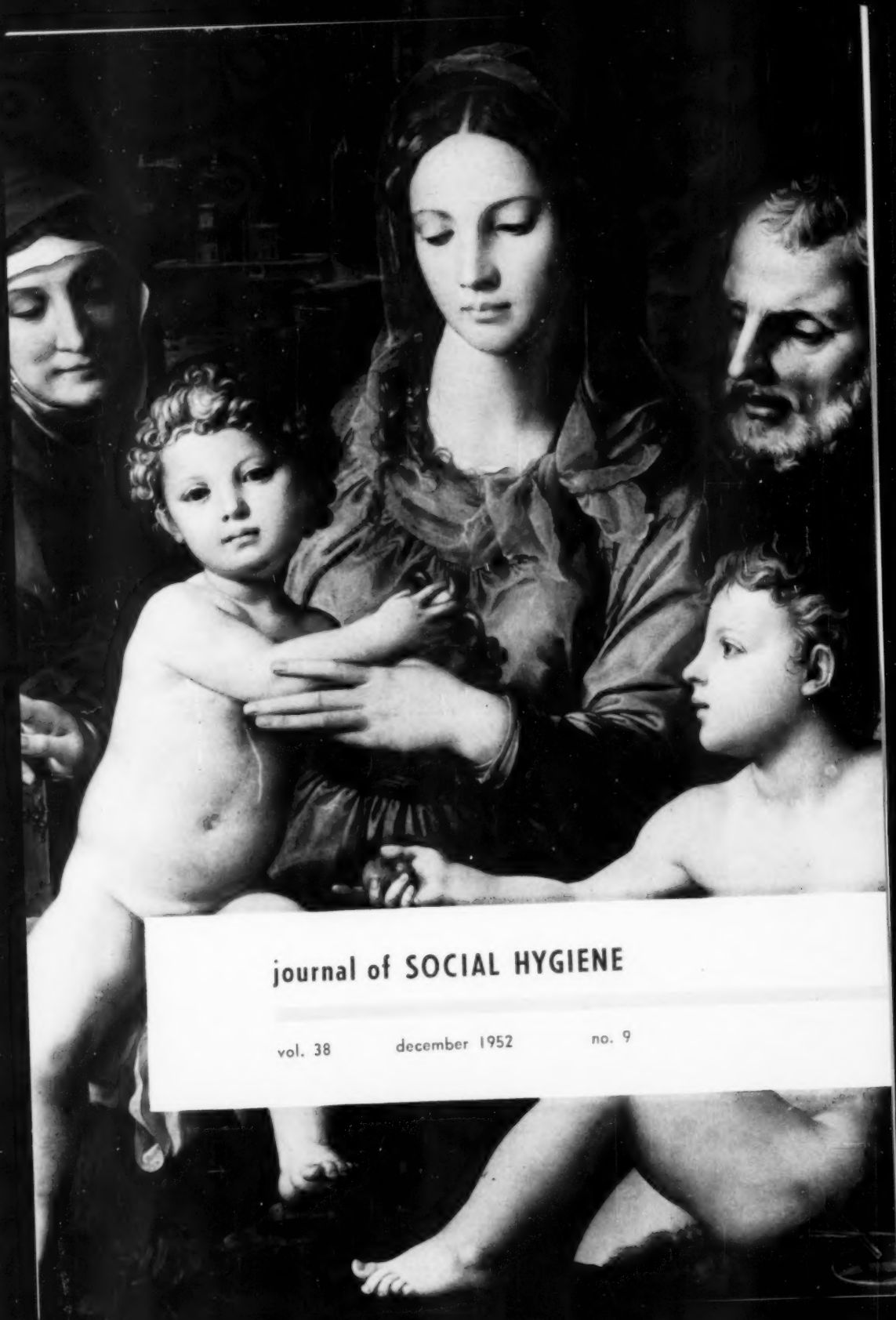

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IN THIS ISSUE

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About our cover . . .

Die Heilige Familie, by Bronzino. Eighteenth of a series of Journal covers on family life . . . photograph courtesy of the Kunsthistorisches Museum, Vienna.

THE JOURNAL OF SOCIAL HYGIENE

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VD officer during World War I.
Then head of the National Health Council.
Later director of health and sanitation for the Office of Inter-American Affairs.
Now a regional representative for ASHA.

Thomas C. Edwards

Social protection — a workable plan

by Thomas C. Edwards

Most people want to live and raise their children in wholesome surroundings.

Some of them realize that a community which tolerates commercialized prostitution attracts other forms of vice. These informed people also know that corruption inevitably accompanies prostitution, and that law enforcement against more serious crimes almost invariably breaks down wherever prostitution exists.

Then there are many civic-minded people who don't condone commercialized prostitution, but simply put up with it . . . if it doesn't try to move into their neighborhood.

Still others—even more misguided—nurture the idea that a wide-open town helps business. They like to think that prostitution is here to stay, and that nothing can be done about it.

But a great deal has been done. It's true the millennium hasn't been reached. But if you look at the record there's conclusive evidence on hand to prove that conditions at the end of 1952 are a lot better than those which existed 40 years ago in many American cities.

The force of public opinion

It's been a rough, tough fight these last 40 years. Today it's much easier to fight the prostitution racket. Practically every state now has laws against most phases of commercialized prostitution.

But laws don't enforce themselves. Enlightened public opinion is a powerful auxiliary weapon for the civic-minded who want to eliminate conditions endangering health and moral welfare. These citizens must make sure that their public officials perform their sworn duty to enforce *all* laws . . . whether they are in sympathy with those laws or not.

One should never forget that a community receives just as much law enforcement against commercialized prostitution as its citizens demand.

Those who claim that prostitution has existed since time began and always will should be told to advocate the repeal of all prostitution legislation. How many would stand up and be counted?

From our long experience we know that most law enforcement officials will institute a vigorous campaign against prostitution activities if they have the backing of citizens.

The citizen in a key position

There are many ways in which you can cooperate with the officials you elect. Here are a few of your responsibilities . . .

- Report to the police those you suspect are identified with the racket.
- Develop and support social services which will work with your public officials by caring for those cases which are beyond the available facilities provided by the city and county governments.
- Reduce your community's crime potential by providing character guidance activities—youth councils, classes on marriage and parenthood, adequate recreation facilities—designed to guide young people in the right direction.

This adds up to good social hygiene . . . which has been defined as "our efforts to *prevent* the illness, unhappiness and tragedy growing out of venereal disease, prostitution and promiscuity. Social hygiene is *prevention*—right training in childhood and youth to achieve right thinking and conduct in maturity. Social hygiene stands as the philosophy and method by which we can generate much of the world's happiness and vigor."

To develop understanding — family life classes.

ASHA's pioneer program

So far, no better means of driving towards that goal have been proposed than the balanced four-fold plan outlined by the American Social Hygiene Association's founders:

- *Medical and public health measures*—to prevent, to cure and at last to eradicate the venereal diseases.
- *Legal and social protection measures*—to wipe out prostitution as an organized business, and to prevent sex delinquency and promiscuity.
- *Educational measures*—to teach the right and highest use of sex in life, as a base and bulwark for the kind of character we need on which to build and maintain family life which insures community growth and national security.
- *Public information and community action*—to energize the other three parts of the social hygiene job, and merge the whole into a steady, active operation.

The second of these goals—legal and social protection measures—has five components:

- Adequate state laws and city ordinances
- Active police
- Understanding courts
- Adequate places of detention giving maximum attention to rehabilitation
- Voluntary agencies helping to return offenders to useful life

As to the first, many states have adequate laws against prostitution. Others could make their laws considerably more effective.

The police and public opinion

My experience with police departments in many communities of all sizes and in all parts of the country convinces me that when the police understand that citizens want effective law enforcement, the police provide it. Where trouble exists in any great proportion it rises more from the citizens' lack of desire for a clean community than from the police department's lack of know-how.

If the police resist public pressure, as they have done in a few instances, communities can clean up only after a grand jury has thoroughly investigated the situation and recommended removal of the recalcitrant officials.

Harassing the procurer

Even then the job isn't done. Constant vigilance is necessary. Exploiters of all descriptions must be ferreted out and eliminated by one legal means or another, for they are the ones responsible for most of the prostitution that exists.

We can have compassion for the girl or woman who is involved, but for the individual who exploits her we can feel only the greatest contempt. Most often, this go-between is a porter, bellboy, cabdriver or hotel clerk.

If constant raids and the placing of uniformed police officers at the entrance or in the lobby of offending establishments are ineffective, the use of the injunction and abatement law is successful. Most property owners will evict tenants when they realize that injunction and abatement proceedings may publicize their names and padlock their property.

Prostitution, corruption, weakened law enforcement— an inevitable progression.

Closing the houses

A fact proved many times over is that the closing of brothels does not multiply other kinds of prostitution—neither the streetwalker nor the tavern B-girl. But the closing of brothels does mean that these decentralized operators still require the utmost vigilance on the part of the police.

Over and over again, outstanding police officials point out that to shunt girls across the city limits—and this is still being done in some places—is to make a problem for some good neighboring community and for themselves, because this good neighbor may simply shunt the girls back.

Just to fine and release or jail offenders for short periods is to start the cycle again and to make more work and expense in the future, probably only days later. The American Social Hygiene Association refers to these methods as the revolving-door system. Every means at hand should be employed to break up this vicious circle.

If the police will report to the health department the names of all individuals apprehended on charges of prostitution or promiscuity, the police will thereby greatly help the fight against VD. While it isn't a crime to have VD, those who are infected must be found and treated . . . and treatment is the responsibility of the health department, not of the police nor the court.

Policing hang-outs

Amusement places, hotels, tourist camps, dancehalls, restaurants, bus stations and taxicabs are often favorite hang-outs of prostitutes. Until they feel community pressure and positive police action, tawdry, semi-underworld places and people, unscrupulous juke joints and unsavory hotels will not mend their ways. Not only are they hang-outs for confirmed prostitutes and procurers . . . they are cradles of delinquency for young girls.

In a number of cities, operators of hotels, taverns and taxicabs have set up very effective methods of self-policing with strict rules for the conduct of their employees as well as their customers. The chief problem is not with the better places but with the dissolute spots requiring special police surveillance.

Through careful selection of employees, adequate pay and close supervision, hotels, taverns and cab companies cut down markedly the chances that their employees will resort to procuring prostitutes for customers. On the other hand, where minors of both sexes receive substandard wages, where late hours are necessary and where poor moral conditions exist, promiscuity and prostitution have an open field.

A helping hand for the police

The police have a difficult and incessant job on their hands, and it is hard to find a police chief that will admit having sufficient manpower and womanpower to cope completely with the situation. It is therefore still more important that we citizens help out.

It is not easy to overemphasize the importance of the part grand juries, district attorneys, sheriffs and state and county police can take in the repression of prostitution and promiscuity. In some communities the mere fact that grand juries are in or about to go into session has caused prostitution racketeers to curtail or cease operations entirely. These juries have been of inestimable assistance in forcing clean-ups in communities whose law enforcement officials could not bring them about. In many localities where the local police could not or would not do the job themselves, district attorneys, with the aid of the state police, have been responsible for a complete clean-up.

Such activities usually strengthen the desire for a wholesome community among citizens who had only a casual interest before . . . and often bring about the replacement of complacent officials with more conscientious successors. In short, a live-wire prosecutor can just about control a bad situation if he is so minded.

Sheriffs, county and state police must be relied on to keep the neighborhoods beyond city limits free of prostitution.

We can develop private agencies to rehabilitate the offender.

Court procedure

An excellent statement by the New York Welfare Council sums up a number of the outstanding requirements for sound court procedure in prostitution cases:

- All cases in which women or girls are involved as sex offenders or victims of sex offenses should be concentrated in one court . . . a women's court, if possible. However, if a juvenile court exists, it should handle cases against young girls.

- A limited number of judges, carefully chosen, should be permanently assigned to these courts.

- The judges should draft a code of procedure requiring: a calendar that won't allow lawyers to maneuver their cases before a certain judge; an orderly atmosphere, including registration of visitors to discourage curiosity-seekers; cubicles in which lawyers can talk privately to their clients; entrances kept clear of hangers-on; and a time-limit on the trial of women out on bail so they can't resort to prostitution to pay their lawyers and bondsmen.

- In large cities, a record should be kept of prostitution cases handled by any given lawyer in any year, to indicate organized forces back of the prostitutes. Competent legal service should be available to all women so that they won't find themselves in the hands of those who will exploit them.

- Similarly, lawyers should furnish sworn statements on fees, dates due and source of payment, and defendants should file sworn statements on the source of bail. This helps expose the "system."

- Judges and probation departments should work out a simplified form on which to enter such facts as the defendant's age, family resources, earning capacity, previous history and psychiatric reports if available.

- Sentences should be uniform, and probation should be used when advisable.

- Suspended sentences and short-term commitments should be wholly eliminated. Probation or commitment to institutions offering rehabilitation programs should replace them.

- Judges should consult and plan with probation authorities and heads of institutions for individual cases which give promise of genuine rehabilitation.

The girl delinquent

The fight against delinquency is probably of top priority in any social protection program. A girl's initial offense—depending upon the way the police handle it—may be a determining factor in her life. A girl who is just a stray pick-up today may become a hardened prostitute or she may become a good member of the community and lead a happy life, depending upon how she is handled by the law enforcement people and other community agencies.

In this effort the qualified policewoman is most successful. But an average police officer, if he is interested and knows about community

Court calendars can prevent a judge's monopoly on prostitution cases.

resources, can do a good job. A thorough study of the girl's case and wise recommendations have a strong bearing on her future.

For instance, the child welfare department or a private agency may take care of her. The juvenile court may be used. Her family may be instructed to take over, provided, of course, they are a desirable influence. Detention may still be the answer. I refer here only to early treatment situations, where there is hope of nipping the trouble in the bud.

What is a policewoman?

Too much stress can't be put on the part a trained or qualified policewoman can play in this unhappy drama. But it isn't easy to get a properly trained and experienced woman for the job.

She should have better than average education, good health, social work experience and psychiatric training. She should be attractive, well-adjusted, emotionally mature and level-headed. She must be willing to learn all there is to know about the control of delinquents, and feel a keen interest in this important humanitarian vocation.

Her primary responsibility should be to spot young people in dangerous situations. Her ability to make innumerable friendly contacts with hotel and rooming-house managers, bus and railroad station attendants, bus and truck drivers will determine her success. As soon as these contacts realize she is trying to *help*, there is no end to the cooperation she will receive.

She must constantly inspect places of amusement, taverns and dance-halls as well as bus and railroad stations where girls—especially stray girls and out-of-towners—are apt to show up. Her friendliness, that big-sister sort of approach, is most convincing.

Above all, she should prove her value to her brother officers and win their cooperation and help.

A live-wire district attorney can stimulate a listless police force.

Detention facilities

Here is a short list of policies regarding detention facilities and places of incarceration that was prepared by the Federal Security Agency in cooperation with a number of law enforcement officers:

- Minimum attainable goals for adult and juvenile detention should be agreed upon, and law enforcement officers should then work toward their attainment.

- Law enforcement officers should recognize that while they are responsible for the administration of jails and lockups in most areas, they do not have the responsibility for determining the kind of facility to be provided. Close cooperation with county and city fiscal and administrative authorities is therefore indicated, to the end that proper facilities may be established.

- Pending the establishment of adequate jail systems, law enforcement officers should devote their energies to bringing about standards of cleanliness and sanitation to make health and decency possible for the inmates. They can at least make certain that prisoners do not actually have their health impaired.

- Proper methods of segregation can keep apart inmates who might be harmed, physically or morally, by contact with others. Jails should not be "schools of crime."

- The worst features of enforced idleness should be eliminated through the constructive use of inmates' time.

- People with a legal or moral right to be held elsewhere should never be detained in jail. These people include juveniles, the insane, the feeble-

minded, chronic alcoholics, and anyone who—regardless of ability to raise bail—is a good risk to remain in the community under pledge to appear when required in court.

• The fee system (a per capita amount provided to jails for the maintenance of prisoners) should be discontinued.

Juveniles should not be held in custody any longer than absolutely necessary, especially while awaiting court action. An effort should be made to work out with their parents or guardians a guarantee that they will be kept out of trouble while awaiting the court's decision.

In some communities specially operated detention facilities or subsidized foster homes are available. Travelers Aid and other private agencies can be tremendously helpful in maintaining a constant list of such homes.

If young sex offenders must be incarcerated, their chances for rehabilitation will depend upon the kind of institutions to which they are committed. These should be as near ideal as possible.

When offenders are released, community organizations have their biggest opportunity to be of real service . . . by finding homes for them (or in helping them to adjust to the limitations of their own homes) and by finding jobs for them.

Three basic forces

In any community there are three basic forces which should work together to eliminate prostitution and other vices:

• Active and persistent public agencies such as police, courts, detention facilities, probation, public welfare, health and other services.

• Volunteer groups such as social hygiene societies or committees, health associations, social welfare agencies, Travelers Aid, PTA, church groups and family service associations.

• The general public, whose job is two-fold—to elect good officials and to support and maintain volunteer groups.

Back to the home

Social protection is a tremendously important part of any well-rounded community program for social hygiene. Like most other aspects of life, social protection begins in the home, with a proper and happy family life. For it is in the family that we should get the first precepts of lawful and correct living, and it is to the family that we must look for cooperation in the rehabilitation of those the family fails.

An Artist Diagnoses Sex Offenders

by Priscilla B. Reed

Foreword by Miriam Van Waters, superintendent, Massachusetts Reformatory for Women

The diagnosis and treatment of sex offenders is one of the tasks of those who rely upon the social hygiene movement to help build a worthy civilization.

While only a fraction of the total number of sex offenders are committed to correctional institutions, in a reformatory for women they represent about 80% of the population under sentence.

What is done for them? Unless there is understanding of their emotional life, no fundamental treatment is possible.

At the Reformatory for Women in Framingham we use a variety of methods to get responses which will reveal the inner hurts, fears, anxieties and conflicts of those committed to us. Psychiatry, psychology, religious counseling, group therapy and psychodrama are employed—anything to elicit self-expression.

These methods are often successful. They show us that underneath the presented problem of larceny or assault there is likely to be a sex problem . . . and underneath the sex problem there is likely to be a childhood terror or other form of suffering.

Mrs. Reed's article offers a new approach, for she is an artist with rare psychological insights and intuition. Her present method of diagnosis of emotional conflict has been used about two years now, with three years' previous therapy work leading into the present method in our reformatory.

The results are important for all those who wish to know more about human behavior and the relief of suffering, both in children and adults.

Art therapy—what is it?

The following is a descriptive case study of work being carried on in a new projective technique proposed for use with female delinquents. It bears no similarity to either the Rorschach (or, as it is more commonly known, "ink-blot") test nor to the thematic apperception test. It is not possible at present to make reproductions of color plates used in this test.

Priscilla B. Reed, who does diagnostic work at the Massachusetts Reformatory for Women, is a Graduate of Abbot Academy, the University of Maine and the School of the Museum of Fine Arts, Boston.

because the original plates are not yet copyrighted and the author-designer is the only one possessing them.

Before these color plates were designed as aids in personality diagnosis, I had carried on diagnostic work through the drawings, paintings and small ceramic pieces of a limited number of girls who could come for "art as therapy" in the Massachusetts State Reformatory for Women. These came at their own request or were assigned by the superintendent.

By its very nature the work was slow and limited. We needed to find a method by which designs of diagnostic value could be presented to a larger number of women, many of whom would never be entering the "studio" for work of their own.

New entrants at the reformatory, preferably those whose case histories and psychometrics are unknown, take the test. This gives the examiner an opportunity to make her analysis without prejudice or bias, and serves as a real trial for this process, which is still in its experimental stages.

15 plates

Out of the 40-odd plates originally made, only 15 are still in use. In selecting the 15 we had the help of a practicing psychiatrist, and kept in mind the instructions of research psychologists to achieve a three-fold purpose:

- A minimum of content in the structure
- Progression of color intensity
- Progression of psychological intensity

The project is based on human emotions . . . each subject is asked to express *her feelings* on seeing the plate presented to her. The "seeing" is secondary to the "feeling." A control group, established at a nearby teachers' college, helps to establish the validity of the project as a whole.

Mary—a new inmate

A frightened, pale young woman in the blue dress of the reformatory's receiving section sat before me. Her fingernails were badly bitten. Nervously she glanced about the room, which is furnished with my personal belongings, including books and pictures. It is a large, light, airy and quiet place, removed from the bustle likely to be found in other parts of the building.

This was her first commitment and she was discovering that all sorts and kinds of things happened during the first three weeks. She had been examined physically and mentally . . . and she had been interviewed—by kindly people, but strangers nonetheless—and now here was something else in this informal living-room. Was this woman before her some sort of officer too?

Her first day

The day of her arrival at the reformatory was an indistinct blur. She could remember weeping on the clean, narrow white bed in the small room to which she had been assigned after the receiving officer had asked her to bathe, hand over her clothes and belongings, and put on one of the plain blue dresses she now wore.

At first trays were brought to her room, and she couldn't eat in the small, pleasant dining-room with other people until certain physical checks had been made. Her tears had fallen onto those food trays, but now she felt a little stronger and a little less bewildered.

She felt nothing

Now there was a sort of numbness in her feelings. The woman across the card-table from her seemed to be giving directions in a quiet way. She tried to listen, but her mind wandered.

The woman was asking her to express what she felt about each plate that she would see. How could she do this when she had no feelings at all? What did the lady mean?

As the first plate was handed to her, Mary asked, "How do you mean, *feel*?" The lady merely repeated much of what she had said before.

To Mary this plate she held in her hands was sort of a picture but there seemed to be so little in it. Suddenly the situation began to seem serious, although the lady smiled at her. Embarrassed, Mary felt the tears starting from her eyes as she hastily said, "It's a lonesome road to travel alone."

The lady had been taking notes, Mary couldn't imagine of what . . . now she saw the lady writing what she had said, only there seemed to be more. (There *was* more. The examiner must not only note the subject's verbal responses, but all her gestures as well. It is in large measure for this reason that the tape-recorder has been ruled out as an aid.)

Without realizing it, Mary squirmed in her chair. There was something terribly hard about all this, yet she wasn't sure why. She didn't like to cry, yet somehow she felt so close to it.

She couldn't say that

The lady held up the second plate a minute before passing it to her. Mary *thought*, "How queer, what a strange thing!" She *said*, "People

dancing." She *thought*, "They look naked, but I can't say that. It wouldn't be nice. And how do I know they're people? They look like other things too." (And why did the lady keep writing all the time when she had said hardly anything?)

And so it went on. It seemed as if the plates became harder and harder. She was getting tired. What difference did it make what she said about them? She'd say any old thing that came to her head. The lady was encouraging. Somebody was nuts around here, and she was sure she wasn't, in spite of all the drinking.

Her father

Why was it she was reminded of all her troubles now? On that last plate—why did she say what she did? There was no picture of her father there . . . but suddenly she had thought of the night he came into her room whispering, "Sh!" and got into bed with her. She could never tell her mother what he did, but ever since she had felt dirty and ashamed and it didn't matter what became of her.

There was a little blood on the sheet which she had to quickly wash off before her mother saw it . . . this plate she was looking at seemed to be bloody. Oh, my! She suddenly realized that she had not said anything to the lady for a long time, but she seemed to be writing just the same. Rape was strongly in her mind, but she couldn't say it was her father, so she quickly improvised a first boy friend.

Mary began to cry. I handed her some Kleenex. She asked for another cigarette and I lit it for her. She was ready to go on with the series. I had made notes on her traumatic sexual experience, and by devious responses to other plates, she was revealing a fairly complete personality picture in the realm of feelings, or emotions. An allied difficulty was her drinking because she "was lonely" (rejected), and she "felt ashamed to be lonely." Her husband was "mean" to her, "stayed home just long enough to get her pregnant."

Her husband had been her first boy friend.

How many questions
in how many interviews!

Her husband

Mary felt both mad and sad about her husband . . . but there was the shadow of an old guilt gnawing at her. She *said*, "My father gave me everything I wanted, pretty things. I was his favorite." She *thought*, "He gave me pretty things but he ruined me. I never dared tell my husband, and I've always wondered if he knew I had had relations with someone before I met him. He was my first boy friend."

The reader must here realize that although traumatic sexual experience is seldom discussed in public, many people have known it but have somehow in the course of existence managed to circumvent their difficulty, which doesn't, of course, always take the form Mary's did. But incest occurs more commonly than the average person realizes.

Don't for a moment think that Mary's problem was typical of all women who come to the reformatory. In *her* case, her deepest problems lay in this particular area—her father's incest when she first came into puberty. In another person the emphasis would be on some other topic.

A synthesis

Like diamonds, human problems and their relation to the society in which we live have many facets, and the one is seldom the answer to all. No one response to any single plate in the test series creates the total picture in the final comment the examiner makes when the test is over and the Marys long since have returned to their rooms.

At the classification conference table, the case worker reviews the case report, both the court record and the woman's story. I hear the medical report and the psychometric findings.

I listen carefully and a bit nervously—as would anyone working on an experimental project—for my intuitive findings concerning Mary and her problems may be all off. To date they have not been off, but have

either confirmed material given by other workers or have added to the diagnostic profile which the superintendent needs before recommending treatment.

The emotionally sick

My present project works from one angle alone—the human emotions. Emotionally sick people are everywhere, as testified by ever-increasing world unrest and ever-enlarging mental hospital populations, and it is disturbed personalities—frequently asocial—that we see in our penal institutions. Part of this prevalence is the direct result of an era that considered emotions inferior, unworthy th.ngs, something to be suppressed . . . because tears are a disgrace, laughter often out of place, and temper not to be tolerated.

As an artist I am deeply concerned with these attitudes. Since a truly functioning artist must have well-developed emotions, he is likely to be actively conscious of the emotional responses of others.

In Mary's case, we saw her confusion when she tried to express her feelings about the color plates she saw. Emotionally associative factors were at work in her which made her have frightening memories.

Wisdom plus heart

As a summary, I'd like to quote from James Stephens' *The Crock of Gold* a conversation between two philosophers: "To understand the theory which underlies all things is not sufficient . . . . . wisdom may not be the end of everything. Goodness and kindness are, perhaps, beyond wisdom. . . . . Wisdom is all head and no heart. Behold, brother, you are being crushed under the weight of your head. You are dying of old age while you are yet a child."

Emotions can get out of hand.

How do city people think about VD?

Columbus, Ohio, interviews 990

by John A. Morsell, Ph.D.

In the October 20, 1950, issue of Public Health Reports Dr. Joseph W. Mountin, assistant surgeon-general of the United States Public Health Service, referred to the progress achieved in a quarter-century of venereal disease control when he observed, "We are reaching the point, in fact, where it is possible to speak not only of syphilis control but of the eradication of syphilis."

With this extension of horizons, workers in the field have recognized the need for re-examination and possible revision of their methods and procedures. In this spirit, the Public Health Service's venereal disease division, the Ohio Department of Health and the Columbus, Ohio, health department cooperated with Columbia University's Bureau of Applied Social Research in two studies of the social psychology of venereal disease. Their primary purpose was to obtain information which would aid in more effective application of education to venereal disease case-finding problems.

Here are some of the suggestive findings dealing with public knowledge and opinions of venereal disease. Other findings, dealing with the factors which motivate infected people to volunteer for diagnosis, will be reported in a later number of the Journal of Social Hygiene.

What does the public know?

Although we know the American public has information about venereal disease, we don't know exactly the quality of this information or how it varies among different social groups. Accordingly, the community study with which this paper deals was set up:

• To provide systematic data on the knowledge, interest and attitudes of people in the general population with respect to venereal disease.

• To ascertain the effectiveness of educational measures designed to mold these factors.

The study should be viewed as a single case history. The proportions of people possessing varying degrees of knowledge and different kinds of attitudes are established for Columbus only and may differ in other communities, just as the rate of infection is not the same everywhere. But the elements that make up public opinion and their relationships—the influence of venereal disease *knowledge* on venereal disease *attitudes*, for instance—should have more than local significance.

Area sampling

The method of area sampling, which insured that every member of the Columbus population within the desired age range (18 to 45) had the same chance to be selected, was used to seek 1,000 interviews (actually 990 were obtained) with a representative sample of Columbus residents.

Following this and according to deliberate plan the Community Health Council—in cooperation with state, county and city health agencies—staged a comprehensive publicity and educational program in Columbus. Immediately afterward, a second wave of 1,017 interviews was obtained, on the same basis as the previous one and therefore equally representative of the community. The second group of respondents was interviewed in the same manner as the first, with the addition of certain questions specifically designed to cover the reception of the campaign materials.

Here is our analysis of their knowledge and opinion about venereal disease. Except as noted, the data reported here are those secured from the precampaign sample of 990 interviews.

The level of knowledge

Syphilis and, to a slightly lesser extent, gonorrhea appear to be familiar diseases to the average citizen of Columbus.

When asked whether they had ever heard of these two terms, all but 11 of the 990 respondents expressed familiarity with the term syphilis and all but 63 had heard of the term gonorrhea. Some of those who didn't know the medical terms were familiar with colloquial names for these diseases. Taking this into account, only six people (less than 1%) showed unfamiliarity with syphilis, and only 33 (3%) were not familiar with gonorrhea.

They didn't know the symptoms

Familiarity with the term syphilis, however, is not necessarily associated with any given degree of accurate knowledge about its origins, symptoms and course of development.

Twenty-two percent (somewhat more Negroes than whites) said they didn't know "what troubles or symptoms people usually have when they get syphilis." Moreover, by no means all those who professed to have this information were actually correct in what they said. Among the answers given spontaneously to the question, sores and rash predominated, but there were frequent references to such alleged symptoms as drip, discharge, swollen ankles, fever and general debility. When questioned specifically about each of these in turn, the percentages of people naming sores and rash as syphilis symptoms increased greatly, but there were similar increases in the percentages identifying drip, discharge and swollen ankles.

The proportions among whites and Negroes in these respects were very much alike, although the latter tended again to be less correctly informed. This indicates the continued importance of information about symptoms as part of the venereal disease message.

Symptoms and contagion

Only 65% of the respondents were sufficiently informed to know that the signs and symptoms of syphilis may sometimes be absent or imperceptible. Asked whether one "can give syphilis and not have any signs or symptoms," 14% believed that this was not possible and 21% said that they didn't know. (In this instance, the Negro and white percentages were the same.)

It is reasonable to regard correct knowledge on this point as an important element in a person's alertness to possible infection . . . it seems to need continued, and even expanded, emphasis in the venereal disease educational program.

"Innocent" methods of contracting VD

People's notions regarding the origin of syphilis were explored by the question: "How do people get syphilis?"

The most common answer was, of course, sexual intercourse (given by 76% of whites and 68% of Negroes). But anywhere from 20% to 40% of respondents also mentioned eating or drinking utensils, toilet seats, kissing, non-sexual social contacts, and the congenital route, roughly in that order. (It is, of course, true that syphilis *can* be contracted through non-sexual channels, however infrequent this may be.)

A sizable proportion (three-fifths) of those who failed to mention sexual intercourse at all as a route for infection didn't mention it even when asked: "How do *most* people get syphilis?" This kind of response comes from two types of people:

- Those who apparently are genuinely unaware that syphilis is usually contracted in sexual intercourse.
- Those who are unwilling to acknowledge this source.

This finding suggests that material dealing with non-sexual sources must be carefully presented so that information about the "harmless" or "innocent" modes of acquisition will not supplant or block the recognition that sexual intercourse is the most frequent one.

Attitudes toward venereal disease

The Columbus questionnaire contained a series of questions—general at first but increasingly specific and personal—which sought to disclose the basic attitudes of the respondents toward venereal disease, and toward syphilis in particular.

From queries such as "Why do *people* avoid treatment?" or "Why are *they* afraid others might find out?" to those seeking the respondent's own personal reaction ("Would *you* be afraid others might find out? Why is that?"), the interview probed along the lines of possible guilt feeling, expectations about the reactions of friends, fears about the future in case of infection, and the like.

The answers to these various attitude-questions made it possible to describe a respondent's sentiments toward venereal disease in two ways:

- With respect to the kind of conception, or *image*, he had of syphilis.
- With regard to the degree of *anxiety* he experienced in connection with syphilis.

The image of syphilis

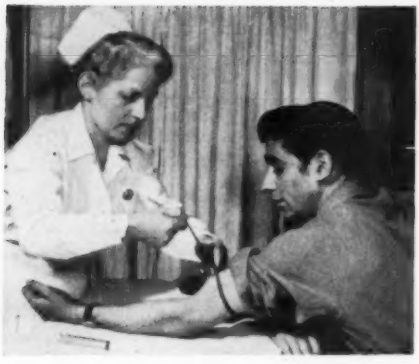
People's feelings about syphilis were found to fall into one or another of three general patterns. In one image, people viewed syphilis primarily as a problem of *individual, personal well-being.* They voiced concern over the physical accompaniments of the disease, such as its unpleasant and painful symptoms, the pain suffered in treatment, its debilitating physical and mental effects if not treated in time.

A second image took its root in the sources of infection. People defined syphilis as a *moral* problem that reflected upon the "sinfulness" or "shamefulness" of the presumed circumstances under which it was contracted.

In a third pattern, the attribute of contagiousness was predominant. Here respondents considered syphilis as a *social,* interpersonal problem, in which they considered the infected person not only a threat to other, and perhaps innocent, people (such as a spouse or children), but also to his friends, who would therefore avoid contact with him. In this conception, syphilis meant social isolation or a deficient sense of social responsibility.

They fear social and moral stigma

Very few respondents expressed only one of these patterns of attitude toward syphilis . . . all three notions were widespread and appeared in the majority of interviews. The average person's image of syphilis may thus



Why do people avoid treatment?

(Posed by model.)

be said to be multidimensional. Herein seems to lie one of the major difficulties of syphilis control, especially as regards volunteering for diagnosis.

A great number of those interviewed clearly considered syphilis a serious disease, and no member of the sample believed that if untreated it might "go away again." Not everyone, of course, has the kind of knowledge which would lead to a suspicion of venereal disease in case of infection . . . people need to know that the disease can be successfully treated (35% of the sample considered syphilis "very hard to cure").

But aside from these factors related to adequate information, the belief that infection will invite social isolation and moral condemnation almost certainly hampers the acknowledgment of infection.

Thus, 50% of the respondents gave shame as their reaction to the possibility that other people might find out that they were being treated for syphilis. Another 5% would be ashamed unless it could be made plain to everyone that they had caught the disease "innocently."

Only 15% replied that they just wouldn't be concerned about public opinion because "all I'd care about is to get healthy." Twenty-seven percent of the cases showed concern for public opinion, but they quickly added that they would "face it" and get treatment anyway.

Fears divorced from knowledge

It seems likely—although it cannot be established by the data of this study—that a person who would fear the discovery that he was being treated for syphilis would be somewhat hesitant about seeking treatment. Although it is true that the respondents in this survey were merely discussing a hypothetical situation, the cure motive might gain in strength if the people were actually infected and suffering from symptoms of the disease.

Also, one should bear in mind that those who are most likely to become infected appear to be less firmly bound by convention (and hence less

sensitive to moral disapproval) than a cross-section of the population such as contained in our sample. But even if the responses we've just discussed don't warrant a prediction of behavior in case of an infection, they do reveal the existence of motives which are essentially in conflict with straight health interests.

Furthermore, these fears, like most of the other attitudes examined in the study, are apparently unaffected by the amount of knowledge which people possess. Differences in knowledge about venereal disease were found to have little or no relation to their opinions about venereal disease.

Syphilis and extramarital relations

Even prior to infection, health concerns which might lead people to take precautions against acquiring VD are not considered of major importance.

The second wave of interviews included two questions aimed at discovering whether fear of catching the disease tended to deter people from illicit sexual relations. Asked to select the most important of several reasons why people do *not* have sex relations outside of marriage, only 29% named fear of syphilis as the most important. (The other reasons were fear of pregnancy, fear of ruining one's chances for marriage, and sinfulness.)

Given the possibility that a way could be found to vaccinate people against syphilis (as with smallpox), only half of the respondents thought that such a vaccination would affect the amount of extramarital sex relations . . . the others stated largely that they didn't think people were "that much worried about catching syphilis."

To summarize the survey findings, while the average citizen of Columbus was convinced that syphilis is dangerous to health, he did not consider this fact a major reason for avoiding possible infectious intercourse, nor did he necessarily consider it the strongest of the many factors likely to affect an individual's course of action *after* contracting an infection.

The level of anxiety about venereal disease

It is apparent from this description of the various ideas about syphilis that people hold that they differ in the intensity of their concern regarding it. Some of them are worried about it. Some are "afraid" of it. Some would feel "guilty" if they found out they had syphilis.

In an attempt to gauge the degree of anxiety, answers to the attitude-questions were rated according to how much "emotion" they appeared to reveal. While only 11% of the respondents expressed attitudes entirely free from worry, the proportion who showed real anxiety ("emotional" reactions to more than half the questions) was relatively small also—25%. The majority of the sample gave a moderate number of responses denoting anxiety.

The low average level of anxiety displayed in Columbus makes it understandable why most people do not consider fear of catching syphilis the

The younger you are when you learn about VD, the more you know.

most important reason for avoiding extramarital sex relations. On the other hand, it seems to be a degree of worry which is consistent with the statement made by 75% that if infected they "would feel careless or stupid for not having taken precaution."

In other words, the average person seems sufficiently worried by the detrimental effects of VD infections upon his health, social status and personal relations that he can be induced to be careful . . . but apparently he is not so afraid that he would be inclined to live differently.

In addition to knowledge, conceptions and degree of anxiety regarding syphilis, a fourth major area of public opinion was investigated. This is the extent to which the average person accepts syphilis as possibly significant for himself personally. While the degree of identification may be related to what a person will actually do in the event of infection, this cannot be determined from the data at hand. What can be learned is whether the degree of identification is likely to affect the amount of venereal disease educational material people receive.

It is well known that those reached by a particular kind of educational message are likely to be those already interested in the topic. (Radio programs devoted to tolerance toward minority groups, for example, tend to reach members of the minority groups or those who already have a tolerant attitude. Political campaign speeches tend to be heard by those politically interested, and particularly by those in favor of the speaker's point of view.) Audience-building then becomes a major part of the promotional task, in addition to the development of a body of information to which we desire to expose the audience.

It therefore seemed important to discover just how much readiness exists on the part of the general public to think of syphilis as a problem that might apply to them personally.

Personal interest in VD

From the answers to several related questions, it was possible to construct a measure for this psychological readiness and to rate the members of the sample according to it.

By and large, the degree of such readiness was not very high.

- While only a handful showed no inclination at all to concern themselves with syphilis, the majority was grouped along the lower half of the scale.

- The attribute was considerably stronger among men than among women.

- It was somewhat more in evidence among Negro than among white respondents.

- There was more of it among respondents from areas of the city having high syphilis incidence rates than among those from low-incidence areas.

- It was unaffected by differences in the amount of schooling.

Whatever the origins of such psychological readiness, there seems no question that it is important to the VD educator in achieving adequate audience penetration by the mass media of communication he employs.

When respondents were asked whether they would be interested in getting more information about venereal disease, the smallest proportion (57%) expressing such interest was found among those whose readiness was rated low. Among those with average readiness ratings, 65% wanted more information, and among respondents with high readiness ratings, 73% were interested in learning more about venereal disease.

These differences hold up regardless of race or sex. Possibly the people who display a high degree of psychological readiness and who also have the most interest in getting more information are exactly the ones in greatest need of this information. No definite answer could be obtained from the community study, because it was not possible to know who among the respondents was infected or most likely to be infected.

But insofar as VD education aims at educating the general public, it must face the fact that one of every two persons who are not themselves personally concerned with the problem says he doesn't *want* to be educated regarding it.

Response to educational material

One aspect of people's experience with venereal disease educational material is, of course, the way in which it affects their knowledge of venereal disease. Here the Columbus data were clear-cut in only one detail—the age at which the person first obtained his knowledge. Those who had learned before they were 20 were much better informed than those who learned after 20. The finding holds for both sexes and both races, regardless of the present age.

As far as the *sources* of their information were concerned, the differences were so slight that it can't be said any one source contributed substantially more than any other . . . partly because most people learned from a variety of sources and the impact of any one main source was blurred. It also reflects the influence of factors other than the nature of the source on the amount of current knowledge which people possessed.

To an extent at least, extensive penetration to the desired audience is clearly the result of the coverage given a topic. This is illustrated by the Columbus demonstration program, which exposed people to more educational matter in one month than they had been exposed to in the fairly normal preceding period of six months.

Perhaps to an equal extent, the degree of penetration is also determined by the level of interest in the topic and in the themes it introduces.

A medical check-up

The Columbus campaign interested mostly those who were psychologically ready to be concerned with the problem of venereal disease . . . and its most consistent effect was to make those it reached think about their own health or about getting a medical check-up.

The campaign analysis appears to point another particularly important lesson: Members of the sample were asked what further kinds of information, if any, they would like to receive. The preference of the great majority was for information on symptoms and treatment. They expressed relatively little liking for material on prevention (which puts responsibility on the individual) or on consequences (which are frightening).

Yet when they were asked later what themes, if any, had induced them to think of their own health (or of a check-up), the most influential themes were those dealing with the consequences of untreated syphilis.

This experience is paralleled by similar results in the realm of commercial advertising, which has also had to develop techniques for the

Most respondents showed little anxiety in answering questions.

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most effective handling of themes which are distasteful or which appeal to fear. The method usually followed is the scare-solution approach, which couples the fear element with the promise of a solution . . . in this case, treatment plus cure. The Columbus campaign did use a scare-solution approach, and the results it achieved were related to this basic method.

A final implication, based on an overall consideration of the survey findings, is that general public concern with the VD problem can be most readily stimulated by careful emphasis on the contagiousness of syphilis—what we have referred to earlier as the social image of the disease. This has the advantage of suiting those whose main concern is the health aspect as well as those who conceive of syphilis as a problem of immorality.

This interpersonal reference coincides with the normal human desire to avoid responsibility for infection and to think of syphilis as something that one "catches," yet it does not encourage the passive-victim frame of mind or a concentration on the "innocent" sources of infection like eating utensils or toilets.

It seems unlikely, at least so far as this study indicates, that VD educational campaigns will soon have much success in inducing people to change the conduct of their private lives. But stress on the dreadful consequences avoided by early treatment, and on contagiousness, which is the problem of the infected as well as of the uninfected person, should help to bring about some increase in preventive behavior as well as more of the desired voluntary action on the part of those who become infected.

Summary

This paper has reviewed some of the findings of a survey of popular knowledge and opinion regarding the venereal diseases based on 990 interviews in Columbus, Ohio. It indicates some of the lessons venereal disease educators may derive from this survey and from the evaluation of a comprehensive educational campaign conducted in connection with the survey.

Can you answer this VD quiz?

Don't look now, but you can find the answers to these questions on page 400 . . .

1. Is syphilis a dangerous disease?
2. Can a person catch syphilis from another person?
3. Is the first sign of syphilis usually a sore?
4. Is syphilis cured when the sore heals?
5. Is a sore the only sign of syphilis?
6. If a sore appears which may be syphilis, is it safe to wait a while before going to the doctor?
7. Does treatment for syphilis take a long time?
8. Is it important to go to a doctor for treatment?
9. Is gonorrhea the same disease as syphilis?
10. Can a person have syphilis and gonorrhea at the same time?
11. Do some people call gonorrhea "the clap," "a dose," "gleet," and "running range"?
12. Is there a gonorrhea sore like the syphilis sore?
13. Does gonorrhea cause trouble if not treated?
14. Can a person catch gonorrhea during sex relations with a person who has it?
15. Do many people have gonorrhea?
16. Can a good doctor cure gonorrhea?
17. Is a reliable doctor the only person who can cure syphilis and gonorrhea?
18. Is it all right to have sex relations when one has syphilis or gonorrhea?
19. Can a person catch VD from utensils, toilets, tools or machines?
20. Is there a way to prevent VD?

Give yourself 5 points for each question you answer right . . .

	YES	NO
NO. 1	☐	☐
NO. 2	☐	☐
NO. 3	☐	☐
NO. 4	☐	☐
NO. 5	☐	☐
NO. 6	☐	☐
NO. 7	☐	☐
NO. 8	☐	☐
NO. 9	☐	☐
NO. 10	☐	☐
NO. 11	☐	☐
NO. 12	☐	☐
NO. 13	☐	☐
NO. 14	☐	☐
NO. 15	☐	☐
NO. 16	☐	☐
NO. 17	☐	☐
NO. 18	☐	☐
NO. 19	☐	☐
NO. 20	☐	☐
SCORE ☐	☐	☐

A score of 50 is not too good . . . 75 is not too bad. If you scored 100, you're a smart person who knows how to protect yourself and your family from VD.

Here are the right answers . . .

1.
Yes. Syphilis can cause miscarriages, stillbirths, heart disease, strokes, blindness, deafness, insanity, paralysis and death.

2.
Yes. A person can catch syphilis by sex relations and other intimate contacts with a person who has syphilis. If a pregnant woman doesn't receive treatment, she can pass syphilis on to her unborn baby.

3.
Yes. One to eight weeks after the syphilis germs get into the body, a sore *usually* appears at the spot where they entered. Sometimes the sore is so small, or hidden, that it isn't noticed. Sometimes it never appears at all.

4.
No. The germs are still alive. They are carried by the bloodstream to all parts of the body . . . where they can do great damage to the heart, blood vessels, brain, nerves, liver, bones and eyes.

5.
No. Other signs are a skin rash, sores in the mouth and throat, swollen glands, headache, fever, pain in the bones. The hair and eyebrows may fall out. These symptoms may be very mild and disappear even without treatment. But the germs are still in the body.

6.
No. See the doctor at once. He can make a diagnosis and cure syphilis, if you have it, with penicillin.

7.
No. Usually only a few days. The sooner you get penicillin, the sooner you will be well again.

8.
Yes. Only a qualified doctor can cure syphilis. Don't trust quacks and patent medicine ads. They only want your money.

9.
No. Gonorrhea and syphilis are two different diseases. Both are catching. Both are dangerous.

10.
Yes. A person can have both diseases at the same time.

11.
Yes. Usually they are people who don't realize how dangerous gonorrhea is.

12.
No. But a few days after the infection there is usually itching and burning, particularly on urinating. Soon a discharge begins to come from the inflamed organs. Women may not notice the symptoms.

13.
Yes. In a man, gonorrhea may damage important glands and make it impossible for him to become a father. It also causes swollen joints and other painful conditions. In a woman, gonorrhea spreads into the internal sex organs and often makes it impossible for her to have children. It sometimes leads to serious operations. In a newborn baby, gonorrhea can cause blindness if the germs get into the baby's eyes.

14.
Yes. Pick-ups and prostitutes often spread gonorrhea to men who then give it to their wives.

15.
Yes. Many people think they're cured when they're not. Others catch gonorrhea during sex relations with these people who aren't cured. Still others put off going to the doctor or try to treat themselves.

16.
Yes. Usually in a few hours.

17.
Yes. Go to your family doctor. If you have none, ask for help at a hospital or at your health department. Don't go to a druggist for medicine to treat yourself. And don't go to a doctor who advertises.

18.
No. Don't have sex relations or kiss anyone until your doctor says you are not infectious.

19.
No. Syphilis and gonorrhea germs quickly die outside the body. Dead germs don't spread diseases.

20.
Yes. Avoid sex relations outside marriage. Don't take chances with pick-ups, free girls and prostitutes. Good behavior is the best way to prevent VD.

Vistas and limits in teaching family life

by Irene H. Williams

Dilemmas aren't new to teachers, but today's teacher faces one of the most exasperating and frustrating pairs of horns ever to confront any group at any time. On the one hand, she is expected to educate "human beings" not "scholars." Her aim is to develop well-rounded, happy, constructive future citizens, not to teach isolated skills. She may feel "old hat" if she concentrates on the three R's, and a failure if she does not promote each year a roomful of creative, well-adjusted personalities.

On the other hand, her study in the field of human growth tells her that a child's basic personality pattern is the direct product of his home experiences. The Midcentury White House Conference on Children underlines the widespread acceptance of this conviction: "In every talk, in every workshop we came back to a recognition of the importance of family life as the foundation of personality development."

This is a difficult paradox. Theoretically, the teacher is not primarily responsible for the child's ability to establish happy social relationships and constructive learning habits. Practically, she feels pressure to assume the burden of his character formation. Guilt and confusion result.

Readin', writin' and 'rithmetic

Some teachers ignore the whole controversy and go on teaching as they have always taught. Some feel guilty over neglecting the majority of the class in concentrating on a few obviously maladjusted students. Many feel anxious, insecure and groping—unsure of goals and uncertain of results. Most find less reward in their work than they should. Not knowing whether they are therapists or educators, they cannot know how to measure their achievements. Time was when a teacher got real satisfaction out of developing a group of good readers, with legible handwriting, and creditable ability in mathematics and other fundamentals.

Today's teacher does not feel satisfied with such accomplishments alone. She must now ask herself in addition, "How well adjusted is this child's total life? How satisfactory are his relationships? Does his social behavior show growth?" These are hard things to measure. In fact, there are as yet no completely satisfactory tools, practical for use in the classroom situation, which do give accurate measurements of such intangibles.

Only by clarifying her own role in the child's development and by realistically defining her own responsibility and goals can the teacher (or

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anyone) be comfortable in her daily work, and find real satisfaction in her job. What does a child need and what can the conscientious teacher realistically expect of herself in relation to these needs?

What every child needs

For optimum development every child needs (in addition to such desirables as a healthy body and normal mentality) truly loving parents and a home life which steadily provides physical, financial, intellectual, moral, social and emotional security to all family members. Deprivations in any of these areas are likely to result in gaps in the stability of the personality.

However, we have come to know that the most damaging lack of all, perhaps the only lack which leaves permanent scars—is deprivation of emotional needs in infancy and early childhood.

A child needs to be a wanted baby, with parents mature enough and happy enough in themselves to be able to give him the gentle care and attention which gradually create his first sense of trust. As a toddler he needs flexible parents who can permit him to take his first steps (literal and symbolic) towards independence without withdrawing the necessary dependent satisfactions—parents who can let him walk alone when he is ready but will be there to soothe the bumps when he flops unexpectedly.

As he becomes more aware of himself and more sensitive to others, he has increasing need of a home where social relationships are harmonious and affectionate, where his parents like each other and him, where attitudes towards others are warm and generous.

Pliable discipline

In such a home a child is loved for what he is. Normal naughtiness, hostile feelings and a reasonable amount of negative behavior are accepted. Discipline is given, but love is not withdrawn. Mistakes are allowed for, but kindly guidance follows them. Standards are high, and parents "stand for" constructive moral and ethical ideals.

But the expectations are not rigid nor impossible to attain, and they are grounded in an understanding of human frailties as well as human potentialities. The child is allowed to be himself and not a carbon copy of

This outstanding article appeared in the *Hawaii Educational Review* last April and in *Child Welfare* last June. Its theme—that the teacher's role in developing a child's personality must have realistic limits—is so reasonably stated that the Journal of Social Hygiene is eager to extend its audience by reprinting the article here with the kind permission of both its previous sponsors.

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an exemplary older relative or a remembered Elsie Dinsmore. Individual differences are enjoyed, not deplored.

In such an atmosphere, a child develops security—a good feeling about himself and his own worth. He has confidence in himself and others, freedom to enter into new experiences, and ability to establish positive relations with people. In such an atmosphere a child prepares for school without fear, undisciplined social habits or emotional blocks.

Because his needs have been richly satisfied, he is ready for a new level of experience. His problems in making an adjustment are ordinarily minor and of short duration. He settles down more or less contentedly to the job of getting as much out of school as is possible for him.

This, then, is what the child—every child—needs before he ever comes to school. He needs the security of a normal, happy home during the first five or six years of life, and he needs it more than he will ever need anything again.

The first five years and the teacher

This the teacher cannot give. She may regret that many of her students lack this kind of emotionally secure background, but she should not hold herself accountable for such lacks, nor expect herself to be able to fill them, nor feel that she has failed if she cannot handle every personality problem she encounters.

What can she do then? Revert to the more circumscribed curriculum and concerns of former years? Dismiss as impractical the ideal of "working with the whole child towards a better integrated personality?" Turn all children presenting problems back to the parents, since they, not she, are fundamentally responsible?

With teachers as overburdened as they are, turning to any of these possibilities would be understandable. A more constructive approach, however, would seem to be the delimiting of areas of responsibility and the concentration within a narrower field upon those things which she can do and which she is in a critical position to do.

She knows about people

She should first of all be as familiar as possible with human behavior, with what is desirable and undesirable in family living, with what factors

Love is a must for baby.

promote healthy growth and what factors inhibit it, what behavior at a given age indicates sound development, and which symptoms spell trouble. She does not need to become a specialist in psychology nor saddle herself with extra "courses" unless her own genuine interests make this rewarding to her.

Mental hygiene experts have pulled together a fascinating body of literature—as fascinating as novels because it is the stuff of which novels are made. Familiarity with this, informal discussions with other teachers or interested friends, seminars such as those being offered in family life education—and most important of all, a continuing curiosity about why people act as they do—will give her sufficient background to look sensitively at the children she teaches.

Patience and understanding

The good teacher has always seen her students as unique individuals, and has tried to increase their security and learning-readiness through kindliness, patience and ego-building encouragement. As love is the common denominator of a good parent, so patient understanding is the common denominator of a good educator. This she must never lose.

It is only if this does not bring the desired results that she must look for additional aids. The failure of this approach is one of the signs that something is deeply wrong in a child, and is in itself an aid to diagnosis.

When the teacher is satisfied that she has made every reasonable effort without stimulating the desired response from the child, the chances are that this is not a classroom problem but one having twisted roots in an unhappy home. To become further absorbed in untangling the difficulties herself would be unfair to the rest of her students and unfruitful to the mixed-up child.

Referral is not "shirking"

At this point other resources must be called in. Through whatever channels are employed in the individual school from the principal, school counselor or the division of pupil guidance, referral should be made to an agency which specializes in the treatment of such problems. The teacher who understands enough about children's problems and enough about community resources to initiate referral procedures where they are appropriate makes a tremendous contribution to her students and her community. (If there are still schools where such teachers must feel that they are "shirking" in not following through themselves, we should all do something about it!)

The class situation itself is often used to promote healthy family life and add to the understanding of behavior through informal discussions. It is not necessary to set aside a special hour for family life education.

The perceptive teacher, always on the alert for material which will be interesting and valuable, extends discussions of regular subjects—why

The relaxed child in school is the loved child at home.

did little Mary in *The Secret Garden* begin to look prettier after she had made friends with the robin and the gardener? What kind of men were Napoleon and other power-hungry leaders? What lies beneath racial prejudices of Nazism, and underneath strong biases in the people we know?

The occasional lapse

More pointedly, from an informal comment, from literature, or pictures, the teacher picks up leads for discussing the normalcy of hostile feelings, jealousy of brothers and sisters (particularly new babies), occasional feelings of inferiority. It is tremendously reassuring to the over-sensitive child to learn:

- That all parents let off steam once in a while.
- That it is good to let out our feelings at times.
- That discipline does not mean rejection.
- That adults as well as children make mistakes.
- That they are sometimes sorry about them but don't know how to say so.
- That no one is, or should expect to be, "perfect."

Group discussion reassuring to child

In such ways, the classroom becomes truly a living experience, concerned with life and centered on the lives assembled together. In such discussions the relaxed atmosphere is more important than the content. The child's security grows from being free to express himself, from having a kindly adult think his ideas are important, and from learning that other people's feelings are much the same as his.

If any child seems unduly upset or volunteers bizarre ideas, it is wise merely to accept his reaction, redirect the discussion, and earmark the incident for further individual exploration.

The teacher can also work directly with parents, not all of them, but some. The signature on a report card is all the teacher sees of some parents . . . but she can see, learn to enjoy, and acquire skill in working with those who do make overtures or respond to invitations to cooperate.

No need to compete with parents

A basic problem of all of us who work with children is the possibility of over-quick identification with the child. That this attitude is felt, not spoken, does not prevent its getting across to the parent. Nor are we slow to respond to their unexpressed critical attitude towards us.

Too often the parent-teacher conference is marked by mutual defensiveness, and is more concerned with justifying individual roles than in understanding the child. "I don't know why you can't handle him at school, he's no problem at home" or "Nancy's so uncooperative. Do you always give her her own way at home?" Such comments quickly put both parent and teacher on guard . . . they feel their abilities questioned and their integrity threatened.

It is of supreme importance for the teacher to remember that even the most "inadequate" parent is doing the best he can at a given moment. He too had parents, deprivations, lack of love, insecurities. Very often he had unhappy school experiences, and he sees you not as a professional adult interested in his child, but as a threatening symbol of authority and criticism.

He may be twice your age, but if his own school days were traumatic, he becomes emotionally (and unconsciously) a frightened eight-year-old. This would be easier to handle if his inward fears were expressed directly in apprehension. Often, however, they are covered up with belligerence. (How many bond issues for better education have been voted down by taxpayers' unconscious negative feelings about their hickory-stick school days?)

The child is father to the man

If the teacher sees in each problem-parent a troubled human being, and can interpret his truculent attitude as directed not to her but to unfortunate experiences with other "authorities" long ago, she can be sufficiently warm and accepting to make at least a dent in the hostile armor.

One brief conference with a friendly, non-condemning teacher will not revamp a grossly pathological home, but it may make possible better parental cooperation with the school and eventually create a receptive attitude towards desired changes.

The resistant child
needs
a specialized agency.

Worthy father, worthy son.

A mother who had been the despair of schools, social agencies and courts because of her marginal home and undisciplined children and who had resisted every approach made to her, was called to school by the teacher of her seriously disturbed son. Expecting the familiar criticism and well equipped to rebuff it, she found herself instead weeping at the teacher's comment, "You must have worried and suffered a lot about Sammy."

She was able to accept referral to a counseling agency and said later that this was the first time anyone had seemed concerned about her, had assumed that she wanted to be a good parent and had suffered because of her failure. Only with this affirmation, and the increased sense of dignity it gave her, was she able to pull herself together and look for appropriate help.

Sugarcoating

A teacher who can approach a parent with liking and sympathy does more than she can ever know or see directly. Nothing is such a "shot in the arm" as encountering, even briefly, someone who likes us and senses sterling virtues in us. The teacher can usually find something for which she can give the parent approval and reassurance. Praise for showing an interest, if nothing else: "It's wonderful when busy parents like you are interested enough to keep in touch with us."

A teacher-parent conference may bring no visible, dramatic changes in a child's adjustment, but if the parent goes home feeling better about

himself (having a better opinion of his worth—feeling more secure), you have, at least temporarily, reduced tension and anxiety in that parent and in the home.

Teachers may forget (thanks to the low pay and heavy demands with which the public rewards them!) that they have a great deal of status. To be talked to as an equal—to have one's opinions elicited by a person with such status, with a reputation for intelligence and learning—is, in itself, an elevating experience for many parents. When this is accompanied by real warmth and humanity a great deal has been given. Then the stage is really set for fruitful discussion of the child with whom both teacher and parent are concerned.

Child feels effect of teamwork

Parents and teachers are the most important influences in a child's life. His security grows when these adults like, respect and trust each other, because his world becomes more stable and trustworthy. People are pulling in the same direction, not at cross purposes. When the child notes differences in the beliefs or methods exemplified at home and school, these can be interpreted as differences, not as wrongs or rights. ("My mother says it's this way" . . . "Yes, many people believe that, but now we are studying another point of view.")

Not all of the job of building vital personalities, happy homes and a free community belongs to the teacher. Parents are still the key figures with major influence upon emotional growth. The teacher can only implement their efforts.

• She does this by preparing herself for her broader responsibilities through awareness of human dynamics and attention to her own mental health.

It's important to give the defensive parent, the belligerent parent, friendly understanding.

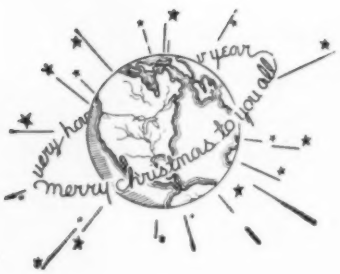
• She does it with children through the creation of a relaxed, supportive learning situation where usable information about behavior supplements academic skills . . . through perception of children whose problems are too deep for handling in the classroom and making appropriate referrals for help elsewhere.

• She does it by breaking down barriers between parents and schools—seeing parents as people, letting them see her as a human being too—and together engaging in a real partnership for the good of children.

A middle course

Society's demands on the teacher in terms of children's personality development may continue to be unrealistically high. Such demands are the expression of parents' deep anxieties and feelings of failure. It would not be helpful for the teacher to reject this implicit plea for assistance nor to try to do the whole job herself.

She must try to look at the overall problem, decide which areas she can tackle, and then devote her skill and energies where they will be effective. She must not feel apologetic nor guilty about not doing more, for her role is a crucial one . . . and her contribution and reward can be truly great.



BOOK NOTES

by Elizabeth B. McQuaid

Essentials of Public Health, by William P. Shepard, M.D. Philadelphia, J. B. Lippincott Company, 1952. 579p. $6.50.

The second edition of *Essentials of Public Health* contains a most comprehensive section on the venereal diseases as part of a chapter on "Special Communicable Disease Control."

The objective of the author and his collaborators—"to present the problems, the goals, the rationale and the usual operations of the public health program in brief, simple and readable style"—has been admirably achieved in this lucid description, of value equally to undergraduate medical students, practicing physicians and students of public health and nursing.

In 20 pages one finds described all the essentials of modern VD control, including a short historical sketch of VD control efforts in the United States.

Social hygiene phases of the VD problem are completely discussed. Difficulties peculiar to venereal infections—such as the questions of morality, promiscuity and prostitution—receive appropriate mention.

Community organization for adequate VD control is covered, stressing the activities of the physician as well as the health authority in case-finding, contact-finding, and proper diagnosis and treatment.

This section on venereal disease control embodies the latest information on the subject, and is highly recommended.

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An Annotated Bibliography in Family Life Education, by Marvin Vick, Jr. Jonesboro Heights, Sanford, N. C., North Carolina Family Life Council, 1951. 97p. $2.00.

For librarians, social workers, counseling agencies and family life educators, this bibliography answers the question, "What books on family life education are available?" Prepared under the direction of the North Carolina Family Life Council, it lists books published in the United States that are currently in print.

In 18 sections—headed for instance, "A Study of Marriage," "Parent-Child Relations," "Family Conflict"—books are arranged alphabetically by author. There is a brief description of content but no evaluation. Related sociological, psychiatric and psychological readings are also included.

Marriage: the Art of Lasting Love, by David H. Mace. New York, Doubleday, 1952. 206p. $2.75.

The purpose of the book is best stated by the author in the foreword: "I am concerned not so much with the scientific as with the artistic, aesthetic, emotional approach to marriage."

With remarkable fidelity he has unfolded this too much submerged aspect of marriage. Chapter 9, "The Art of Married Love," is the high point and pivot in the development of the theme. The reader is impressed with Dr. Mace's philosophy of life—that all living is an art and is not achieved merely by knowing a number of scientific facts.

So in marriage, knowledge of techniques, skills or the sum of a number of facts does not assure even minimal sexual harmony. Dr. Mace uses clinical material in chapter 19: "She knew just when Harold got to the foot of page 5 and turned over to page 6. It became a routine which habitually ended in failure." Yet there is a wealth of factual data to illustrate how knowledge can contribute to making an art of marriage.

Dr Mace challenges the thought of those looking ahead to marriage as well as those already married. "For the man, love is something he has to give in order to gain the thing he really wants, which is sex. For the woman, sex is something she has to give in order to gain the thing she really wants, which is love." And the only way to know whether you agree with Dr. Mace is to read his exposition of this statement.

It is easy to read, entertaining and very helpful to professional social hygiene workers and to ordinary men and women who might try becoming artists in their mating.

F. G. Scherer, Minister
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H Is for Heroin, by David Hulburd. New York, Doubleday, 1952. 122p. $1.75.

This is the factual story of 15-year-old Amy Burton, who drifted from marijuana to heroin and in two years became a confirmed dope addict. In that time she lost all the normal interests of young people, failed to get along with her parents, married a dope addict and divorced him, and spent some time in a state correctional institution.

Mr. Hulburd says that although Amy was reticent about her sexual activities, there is little doubt that her crowd of marijuana smokers indulged in a shocking amount of promiscuity, including mass orgies. Heroin users, on the other hand, lose all interest in sex and concentrate their energies on obtaining the drug by fair means or foul. For teenagers inclined to follow the crowd without considering the consequences, this book should serve as an effective "stop sign."

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ASHA's Job in National Defense

★ To study prostitution conditions, particularly near military installations and industrial centers

★ To prepare fully documented reports on local prostitution conditions for the information and guidance of military and civil authorities

★ To provide community leaders with the facts about the dangers of commercialized prostitution

★ To advise communities on the most effective ways of repressing vice and to recommend ways of treating sexual delinquents

★ To stimulate adequate wholesome recreation as a morale-building safeguard against sexual misconduct

★ To intensify the spread of sound information about venereal disease, particularly to young people entering the Armed Forces

★ To help strengthen family life against the tensions of the times by fighting VD and sexual promiscuity, two major threats to family health and well-being

★ To encourage education for family life, through publications, study courses for parents, and formal training for teachers, youth leaders and others who influence young people

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